		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041855

Facility Name: Lexington of Orland Park

Address: 14601 S. John Humphrey Drive (Number) Orland Park (City) 60462 (Zip Code)

County: Cook

Telephone Number: (708) 349-8300 **Fax #** (708) 349-4093

IDPA ID Number: 363923895001

Date of Initial License for Current Owners: 07/08/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT			x	PROPRIETARY		GOVERNMENTAL
		Charitable Corp.			Individual		State
		Trust			Partnership		County
IRS Exemption Code					Corporation		Other
				x	"Sub-S" Corp.		
					Limited Liability Co.		
					Trust		
					Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser, LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	270	Skilled (SNF)	270	98,550	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	270	TOTALS	270	98,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,502	1,848	15,282	33,632	8
9	SNF/PED					9
10	ICF	49,895	5,789	542	56,226	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,397	7,637	15,824	89,858	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.18%

D. How many bed-hold days during this year were paid by Public Aid?
257 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/8/96

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date New construction NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 59 and days of care provided 8,982

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	326,568	40,024	16,818	383,410		383,410		383,410			1
2	Food Purchase		355,875		355,875		355,875	(14,302)	341,573			2
3	Housekeeping	298,514	49,624		348,138		348,138	929	349,067			3
4	Laundry	56,059	29,619		85,678		85,678	(3,489)	82,189			4
5	Heat and Other Utilities			207,165	207,165		207,165	4,962	212,127			5
6	Maintenance	108,928		128,865	237,793		237,793	2,099	239,892			6
7	Other (specify):*											7
8	**TOTAL General Services**	790,069	475,142	352,848	1,618,059		1,618,059	(9,801)	1,608,258			8
	B. Health Care and Programs											
9	Medical Director			24,750	24,750		24,750		24,750			9
10	Nursing and Medical Records	3,623,908	293,930	24,475	3,942,313		3,942,313		3,942,313			10
10a	Therapy			1,078,686	1,078,686		1,078,686		1,078,686			10a
11	Activities	243,835	17,864	5,993	267,692		267,692		267,692			11
12	Social Services	67,672		2,329	70,001		70,001		70,001			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,935,415	311,794	1,136,233	5,383,442		5,383,442		5,383,442			16
	C. General Administration											
17	Administrative	212,825		541,191	754,016		754,016	(541,191)	212,825			17
18	Directors Fees											18
19	Professional Services			106,616	106,616		106,616	(13,186)	93,430			19
20	Dues, Fees, Subscriptions & Promotions			35,785	35,785		35,785	2,468	38,253			20
21	Clerical & General Office Expenses	535,132	38,555	34,513	608,200		608,200	28,315	636,515			21
22	Employee Benefits & Payroll Taxes			639,175	639,175		639,175	87,174	726,349			22
23	Inservice Training & Education			913	913		913		913			23
24	Travel and Seminar			2,246	2,246		2,246	3,896	6,142			24
25	Other Admin. Staff Transportation							12,777	12,777			25
26	Insurance-Prop.Liab.Malpractice			237,646	237,646		237,646	4,245	241,891			26
27	Other (specify):*											27
28	**TOTAL General Administration**	747,957	38,555	1,598,085	2,384,597		2,384,597	(415,502)	1,969,095			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,473,441	825,491	3,087,166	9,386,098		9,386,098	(425,303)	8,960,795			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Lexington of Orland Park #0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			38,340	38,340		38,340	307,007	345,347			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			11,299	11,299		11,299	559,826	571,125			32
33	Real Estate Taxes							468,540	468,540			33
34	Rent-Facility & Grounds			1,905,749	1,905,749		1,905,749	(1,905,749)				34
35	Rent-Equipment & Vehicles			7,814	7,814		7,814	5,865	13,679			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,963,202	1,963,202		1,963,202	(564,511)	1,398,691			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		211,482	67,093	278,575		278,575		278,575			39
40	Barber and Beauty Shops			34,061	34,061		34,061		34,061			40
41	Coffee and Gift Shops			648	648		648		648			41
42	Provider Participation Fee			147,825	147,825		147,825		147,825			42
43	Other (specify):* Nonallowable Costs			262,485	262,485		262,485	(262,485)				43
44	**TOTAL Special Cost Centers**		211,482	512,112	723,594		723,594	(262,485)	461,109			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,473,441	1,036,973	5,562,480	12,072,894		12,072,894	(1,252,299)	10,820,595			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(145)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(3,489)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(3,045)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,223)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(253,758)	43		24
25	Fund Raising, Advertising and Promotional	(10,819)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax	3,315	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule A	(897,792)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (1,166,956)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(85,343)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (85,343)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,252,299)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Orland Park, Inc.
Provider #0041855
1/1/02- 12/31/02

Schedule A

Schedule VI. Adjustment Detail
Line 29, Other

Description	Amount	Reference
Deferred maintenance amortization	733	6
Nonallowable collections	(16,550)	19
Out of period legal fees	(1,572)	19
Out of period consulting fees	(8,019)	19
Offset miscellaneous income	(3,918)	21
Nonallowable unrealized loss on fair value of an interest rate swap	(868,466)	43
Total	(897,792)	

See Accountants' Compilation Report

Lexington of Orland Park

ID# 0041855

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lexington of Orland Park # 0041855 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(145)	0	0	0	0	0	0	0	0	0	0	(145)	2
3	Housekeeping	0	0	929	0	0	0	0	0	0	0	0	929	3
4	Laundry	(3,489)	0	0	0	0	0	0	0	0	0	0	(3,489)	4
5	Heat and Other Utilities	0	0	4,962	0	0	0	0	0	0	0	0	4,962	5
6	Maintenance	0	0	1,366	0	0	0	0	0	0	0	0	1,366	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,634)	0	7,257	0	0	0	0	0	0	0	0	3,623	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(541,191)	0	0	0	0	0	0	0	(541,191)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	83	12,872	0	0	0	0	0	0	0	0	12,955	19
20	Fees, Subscriptions & Promotions	0	0	2,468	0	0	0	0	0	0	0	0	2,468	20
21	Clerical & General Office Expenses	0	1,755	30,478	0	0	0	0	0	0	0	0	32,233	21
22	Employee Benefits & Payroll Taxes	0	0	73,017	0	0	0	0	0	0	0	0	73,017	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,896	0	0	0	0	0	0	0	0	3,896	24
25	Other Admin. Staff Transportation	0	0	0	12,777	0	0	0	0	0	0	0	12,777	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	4,245	0	0	0	0	0	0	0	4,245	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	1,838	122,731	(524,169)	0	0	0	0	0	0	0	(399,600)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,634)	1,838	129,988	(524,169)	0	0	0	0	0	0	0	(395,977)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lexington of Orland Park # 0041855 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	272,583	0	34,424	0	0	0	0	0	0	0	307,007	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,045)	557,301	0	5,570	0	0	0	0	0	0	0	559,826	32
33	Real Estate Taxes	0	465,748	0	2,792	0	0	0	0	0	0	0	468,540	33
34	Rent-Facility & Grounds	0	(1,905,749)	0	0	0	0	0	0	0	0	0	(1,905,749)	34
35	Rent-Equipment & Vehicles	0	0	0	5,865	0	0	0	0	0	0	0	5,865	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(3,045)	(610,117)	0	48,651	0	0	0	0	0	0	0	(564,511)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(262,485)	868,466	0	0	0	0	0	0	0	0	0	605,981	43
44	**TOTAL Special Cost Centers**	(262,485)	868,466	0	0	0	0	0	0	0	0	0	605,981	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(269,164)	260,187	129,988	(475,518)	0	0	0	0	0	0	0	(354,507)	45

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Samatas Discretionary Trust	30.00%			Lexington Health Care		
John Samatas Discretionary Trust	30.00%			Systems of Orland		
Cynthia Thiem Discretionary Trust	30.00%	See attached Schedule B		Park Ltd. Ptsp.	Orland Park	Real estate ptsp.
Dean Sweitzer	10.00%			Royal Mgmt. Corp.	Lombard	Mgmt. Co.
				Lexington Financial		
				Services, L.L.C.	Lombard	Finance Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental expense	$ 1,905,749	Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	$	$ (1,905,749)	1
2	V	19	Professional fees		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	83	83	2
3	V	21	Office supplies expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	75	75	3
4	V	30	Depreciation		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	272,583	272,583	4
5	V	32	Interest expense		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	550,748	550,748	5
6	V	32	Amortization of mortgage costs		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	6,553	6,553	6
7	V	33	Property taxes		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	465,748	465,748	7
8	V	21	Administrative expenses		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	1,680	1,680	8
9	V	43	Unrealized loss on fair value of interest rate swap		Lexington Health Care Systems of Orland Park Ltd. Ptsp	**	868,466	868,466	9
10	V								10
11	V								11
12	V				**The owners of Lexington Health Care Center of Orland Park, Inc. own 100%				12
13	V				of Lexington Health Care Systems of Orland Park Ltd Ptsp.				13
14	Total			$ 1,905,749			$ 2,165,936	$ * 260,187	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Orland Park, Inc.
Provider # 0041855 **Schedule B**
1/1/02 - 12/31/02

VII. Related Parties
Related Nursing Homes

Name of facility	City
Lexington Health Care Center of Lombard, Inc.	Lombard
Lexington Health Care Center of Bloomingdale, Inc.	Bloomingdale
Lexington Health Care Center of Chicago Ridge, Inc.	Chicago Ridge
Lexington Health Care Center of Elmhurst, Inc.	Elmhurst
Lexington Health Care Center of LaGrange, Inc.	LaGrange
Lexington Health Care Center of Lake Zurich, Inc.	Lake Zurich
Lexington Health Care Center of Schaumburg, Inc.	Schaumburg
Lexington Health Care Center of Streamwood, Inc.	Streamwood
Lexington Health Care Center of Wheeling, Inc.	Wheeling

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	Housekeeping supplies	$	Royal Management Corp.	**	$ 929	$ 929	15
16	V	5	Utilities - gas & electric		Royal Management Corp.	**	4,727	4,727	16
17	V	5	Utilities - water & sewer		Royal Management Corp.	**	235	235	17
18	V	6	Repairs & maintenance		Royal Management Corp.	**	1,291	1,291	18
19	V	6	Scavenger & exterminating		Royal Management Corp.	**	56	56	19
20	V	6	Security service		Royal Management Corp.	**	19	19	20
21	V	19	Computer consultant & supplies		Royal Management Corp.	**	10,254	10,254	21
22	V	19	Professional fees		Royal Management Corp.	**	2,618	2,618	22
23	V	20	Advertising - help wanted		Royal Management Corp.	**	1,482	1,482	23
24	V	20	Dues & subscriptions		Royal Management Corp.	**	986	986	24
25	V	21	Bank charges		Royal Management Corp.	**	3,421	3,421	25
26	V	21	Communications		Royal Management Corp.	**	684	684	26
27	V	21	Office supplies & printing		Royal Management Corp.	**	12,965	12,965	27
28	V	21	Postage		Royal Management Corp.	**	4,072	4,072	28
29	V	21	Telephone		Royal Management Corp.	**	9,336	9,336	29
30	V	22	FICA		Royal Management Corp.	**	39,360	39,360	30
31	V	22	FUTA		Royal Management Corp.	**	723	723	31
32	V	22	SUTA		Royal Management Corp.	**	788	788	32
33	V	22	Insurance - W/C		Royal Management Corp.	**	912	912	33
34	V	22	Insurance - hospitalization		Royal Management Corp.	**	22,895	22,895	34
35	V	22	401(k) and other emp. benefits		Royal Management Corp.	**	8,339	8,339	35
36	V	24	Travel & seminar		Royal Management Corp.	**	3,896	3,896	36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.						38
39	Total			$			$ 129,988	$ * 129,988	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	25	Auto expense	$	Royal Management Corp.	**	$ 12,777	$ 12,777	15
16	V	26	Insurance - general		Royal Management Corp.	**	4,245	4,245	16
17	V	30	Depreciation - vehicles		Royal Management Corp.	**	4,557	4,557	17
18	V	30	Depreciation - leasehold improv.		Royal Management Corp.	**	8,953	8,953	18
19	V	30	Depreciation - equipment		Royal Management Corp.	**	20,914	20,914	19
20	V	32	Interest		Royal Management Corp.	**	5,570	5,570	20
21	V	33	Property taxes		Royal Management Corp.	**	2,792	2,792	21
22	V	35	Equipment rental		Royal Management Corp.	**	5,865	5,865	22
23	V	17	Management fees	541,191	Royal Management Corp.	**		(541,191)	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		**Certain owners of Lexington Health Care Center of Orland Park, Inc. own 100% of Royal Management Corp.						38
39	Total			$ 541,191			$ 65,673	$ * (475,518)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Orland Park, Inc.
Provider # 0041855 **Schedule C**
1/1/02 - 12/31/02

VII. Related Parties
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of the Board of Directors

5. Compensation Received From Other Nursing Homes

Name of facility	John Samatas	James Samatas	Cynthia Thiem	George Samatas	Jason Samatas	Total
Lexington Health Care Center of Bloomingdale, Inc.	13,617	30,638	17,021	4,085	10,318	75,679
Lexington Health Care Center of Chicago Ridge, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Elmhurst, Inc.	11,875	26,719	14,844	3,563	8,998	65,999
Lexington Health Care Center of LaGrange, Inc.	8,629	19,416	10,787	2,589	6,538	47,959
Lexington Health Care Center of Lake Zurich, Inc.	16,071	36,160	20,089	4,821	12,177	89,318
Lexington Health Care Center of Lombard, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Schaumburg, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Streamwood, Inc.	17,734	39,901	22,167	5,320	13,437	98,559
Lexington Health Care Center of Wheeling, Inc.	17,496	39,367	21,870	5,249	13,258	97,240
Total	138,624	311,904	173,279	41,587	105,037	770,431

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	James Samatas	Owner/officer	Administrative	30.00%	See Schedule C	6	13.00%	Salary	$ 48,096	L17, C1	1
2	John Samatas	Owner/officer	Admin/Plant Ops	30.00%	See Schedule C	3	15.00%	Salary	21,376	L17, C1	2
3	Cynthia Thiem	Owner/officer	Administrative	30.00%	See Schedule C	3	15.00%	Salary	26,721	L17, C1	3
4	George Samatas	Officer	Administrative	0.00%	See Schedule C	3	15.00%	Salary	6,413	L17, C1	4
5	Jason Samatas	VP of Operations	Administrative	0.00%	See Schedule C	7	14.00%	Salary	16,194	L17, C1	5
6	Dean Sweitzer	Owner*	Administrative	10.00%	103,327	5	10.00%	Salary	13,805	L21, C1	6
7											7
8											8
9											9
10		* Dean Sweitzer is an owner only in Lexington Health Care Center of Orland Park, Inc. He is an employee									10
11		of Royal Management Corp. and provides administrative services to Royal Management Corp. His compensation									11
12		has been allocated to all 10 Lexington facilities.									12
13								TOTAL	$ 132,605		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping supplies	Bed Days	737,665	10	$ 6,954	$	98,550	$ 929	1
2	5	Utilities - gas & electric	Bed Days	737,665	10	35,380		98,550	4,727	2
3	5	Utilities - water & sewer	Bed Days	737,665	10	1,765		98,550	235	3
4	6	Repairs & maintenance	Bed Days	737,665	10	9,640		98,550	1,291	4
5	6	Scavenger & exterminating	Bed Days	737,665	10	438		98,550	56	5
6	6	Security service	Bed Days	737,665	10	150		98,550	19	6
7	19	Computer consultant & supplies	Bed Days	737,665	10	76,767		98,550	10,254	7
8	19	Professional fees	Bed Days	737,665	10	19,590		98,550	2,618	8
9	20	Advertising - help wanted	Bed Days	737,665	10	11,111		98,550	1,482	9
10	20	Dues & subscriptions	Bed Days	737,665	10	7,373		98,550	986	10
11	21	Bank charges	Bed Days	737,665	10	25,613		98,550	3,421	11
12	21	Communications	Bed Days	737,665	10	5,118		98,550	684	12
13	21	Office supplies & printing	Bed Days	737,665	10	97,051		98,550	12,965	13
14	21	Postage	Bed Days	737,665	10	30,484		98,550	4,072	14
15	21	Telephone	Bed Days	737,665	10	69,873		98,550	9,336	15
16	22	FICA	Bed Days	737,665	10	294,613		98,550	39,360	16
17	22	FUTA	Bed Days	737,665	10	5,419		98,550	723	17
18	22	SUTA	Bed Days	737,665	10	5,907		98,550	788	18
19	22	Insurance - W/C	Bed Days	737,665	10	6,829		98,550	912	19
20	22	Insurance - hospitalization	Bed Days	737,665	10	171,371		98,550	22,895	20
21	22	401(k) and other emp. benefits	Bed Days	737,665	10	62,427		98,550	8,339	21
22	24	Travel & seminar	Bed Days	737,665	10	29,161		98,550	3,896	22
23										23
24										24
25	TOTALS					$ 973,034	$		$ 129,988	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Royal Management Corp.
Street Address: 665 W. North Avenue, Suite 500
City / State / Zip Code: Lombard, IL 60148
Phone Number: (630) 458-4700
Fax Number: (630) 458-4796

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	25	Auto expense	Bed Days	737,665	10	$ 95,636	$	98,550	$ 12,777	1
2	26	Insurance - general	Bed Days	737,665	10	31,776		98,550	4,245	2
3	30	Depreciation - vehicles	Bed Days	737,665	10	34,112		98,550	4,557	3
4	30	Depreciation - leasehold improv.	Bed Days	737,665	10	66,995		98,550	8,953	4
5	30	Depreciation - equipment	Bed Days	737,665	10	156,541		98,550	20,914	5
6	32	Interest	Bed Days	737,665	10	41,692		98,550	5,570	6
7	33	Property taxes	Bed Days	737,665	10	20,881		98,550	2,792	7
8	35	Equipment rental	Bed Days	737,665	10	43,917		98,550	5,865	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 491,550	$		$ 65,673	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Lexington Financial Services						$	$			$	1
2	L.L.C.	x		Mortgage	Varies	12/29/98	9,000,000	8,384,584	02/01/2026	Variable	550,748	2
3												3
4												4
5												5
	Working Capital											
6	LaSalle Bank N.A.		x	Line of credit	Varies	04/06/02	1,000,000	600,000	04/05/2003	0.0425	11,299	6
7												7
8												8
9	TOTAL Facility Related						$ 10,000,000	$ 8,984,584			$ 562,047	9
	B. Non-Facility Related*											
10								Amortization of loan costs			6,553	10
11								Interest income offset			(3,045)	11
12								Allocated from management company			5,570	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 9,078	14
15	TOTALS (line 9+line14)						$ 10,000,000	$ 8,984,584			$ 571,125	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # N/A

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.		$ 470,000	1
	Allocated from management company	2,792	
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	$ 455,748	2
3. Under or (over) accrual (line 2 minus line 1).		$ (11,460)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 480,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 468,540	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	243,871	8
	1998	386,799	9
	1999	434,461	10
	2000	441,101	11
	2001	455,748	12

2001 taxes:	455,748
Estimated increase (5.0%):	1.050
Estimated 2002 taxes	478,535
Use:	480,000

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lexington of Orland Park COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0041855

CONTACT PERSON REGARDING THIS REPORT Susan Rojek

TELEPHONE (630) 458-4700 FAX #: (630) 458-4795

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	27-10-100-099-0000	Land and building	$ 455,748.60	$ 455,748.60
2.	Royal Management Corp. (Omni Partners)		$	$
3.	06-19-201-018	Land and building	$ 70,162.00	$ 196.00
4.	Royal Management Corp. (Samvest		$	$
5.	05-01-202-019	Land and building	$ 144,399.00	$ 2,596.00
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 670,309.60	$ 458,540.60

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 104,332 B. General Construction Type: Exterior Brick Frame Block and Pre-cast stee Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A

3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	152,460	1995	$ 776,408	1
2	Mgmt. Co.		2002	21,752	2
3	TOTALS	152,460		$ 798,160	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	250		1996	1996	$ 8,455,949	$	40	$ 211,399	$ 211,399	$ 1,372,936	4
5	10		1998	1998	63,790	1,595	40	1,595		6,379	5
6	10		2001	2001							6
7											7
8											8
	Improvement Type**										
9	Electrical wiring			1996	2,304	58	40	58		355	9
10	Paving			1997	11,589		40	773	773		10
11	Additional building costs			1996	113,337		40	2,833	2,833		11
12	Wiring			1998	3,932	393	10	393		1,770	12
13	Additional building costs - 10 bed additior			1999	1,808	45	40	45		181	13
14	Seal/restrip parking lot			1999	3,450	230	15	230		805	14
15	Wiring			1999	1,798	45	40	45		157	15
16	Roof repairs			2000	23,201	1,547	15	1,547		3,867	16
17	Electrical wiring			2000	5,732	164	35	164		409	17
18	Ceiling mount curtain rod hardwarc			2000	6,952	199	35	199		497	18
19	Automatic door closer/sensors			2000	3,624	242	15	242		604	19
20	Seal and restripe parking lot			2001	2,277	228	10	228		342	20
21	HVAC control			2001	2,548	255	10	255		382	21
22	Infrared curtains for elevator doors			2001	4,500	450	10	450		675	22
23	Fire alarm panel			2002	5,120	256	10	256		256	23
24	Parking lot lights			2002	9,975	499	10	499		499	24
25	Chiller room compressor			2002	8,879	888	5	888		888	25
26	Carpeting			2002	7,037	704	5	704		704	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Leasehold improvements - management company	1995	$ 13,788	$	35	$ 498	$ 498	$ 2,954	37
38	Leasehold improvements - management company	1996	11,222		35	407	407	2,082	38
39	Leasehold improvements - management company	1989	386		31	14	14	180	39
40	HVAC - management company	1998	291		35	11	11	44	40
41	Offices - management company	1999	734		35	27	27	71	41
42	Offices - management company	2000	346		35	13	13	27	42
43	Land improvements - management company	2002	13,047		15	799	799	799	43
44	Building - management company	2002	304,161		40	6,971	6,971	6,971	44
45	Sewer & water improvements - management company	2002	6,919		30	213	213	213	45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,088,696	$ 7,798		$ 231,756	$ 223,958	$ 1,405,047	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 795,397	$ 29,516	$ 87,094	$ 57,578	5-10 years	$ 499,561	71
72	Current Year Purchases	10,263	1,026	1,026		5 years	1,026	72
73	Fully Depreciated Assets							73
74	Allocated from management company	208,874		20,914	20,914		54,636	74
75	TOTALS	$ 1,014,534	$ 30,542	$ 109,034	$ 78,492		$ 555,223	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79	Allocated from management company			40,792		4,557	4,557		28,386	79
80	TOTALS			$ 40,792	$	$ 4,557	$ 4,557		$ 28,386	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 10,942,182	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 38,340	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 345,347	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 307,007	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,988,656	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 13,679 Description: Postage meter: $1,757; Copier: $6,057; Allocated from management company: $5,865
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	36,237	$ 423,924	$	36,237	$ 423,924	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		7,309	94,956		7,309	94,956	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		46,848	559,806		46,848	559,806	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				211,482		211,482	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See attached Sch. D					67,093			67,093	13
14	TOTAL			$	90,394	$ 1,145,779	$ 211,482	90,394	$ 1,357,261	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington of Orland Park
Provider #: 0041855
01/01/02 to 12/31/02

Schedule D

XIV. Special Services
Line 13, Other

Service	Cost	Line Reference
Oxygen	18,650	L39, C3
Radiology	12,980	L39, C3
Clinitron beds	31,788	L39, C3
Laboratory	3,675	L39, C3
Total	67,093	

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 933,480	$ 936,847	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 1,043,588)	3,556,202	3,556,202	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	87,351	87,351	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	43,621	51,428	8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,620,654	$ 4,631,828	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	79,301	79,301	12
13	Land		798,160	13
14	Buildings, at Historical Cost		8,569,286	14
15	Leasehold Improvements, at Historical Cost	156,927	519,410	15
16	Equipment, at Historical Cost	229,878	1,055,326	16
17	Accumulated Depreciation (book methods)	(123,851)	(1,988,656)	17
18	Deferred Charges		366	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Unamortized mortgage costs		139,412	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 342,255	$ 9,172,605	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,962,909	$ 13,804,433	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 557,420	$ 557,420	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	588,197	588,197	28
29	Short-Term Notes Payable		14,584	29
30	Accrued Salaries Payable	214,556	214,556	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,393	9,393	31
32	Accrued Real Estate Taxes(Sch.IX-B)		480,000	32
33	Accrued Interest Payable		67,574	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule E	564,263	109,304	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,933,829	$ 2,041,028	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	600,000	600,000	39
40	Mortgage Payable		8,370,000	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Interest rate swap liability		868,466	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 600,000	$ 9,838,466	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,533,829	$ 11,879,494	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,429,080	$ 1,924,939	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,962,909	$ 13,804,433	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Lexington Health Care Center of Orland Park, Inc.
Provider # 0041855
1/1/02 - 12/31/02 **Schedule E**

XV. Balance Sheet
C. Current Liabilities

36. Other Current Liabilities

Description	Operating	After Consolidation
Accrued rent	454,959	
Accrued management fees	34,475	34,475
Accrued 401 (k) contribution	4,846	4,846
Due to related party	2,455	2,455
401 (k) withholding	1,577	1,577
Other accrued expenses	65,951	65,951
Total line 36	564,263	109,304

XVII. Income Statement
E. Other Revenue

28. Other Revenue

Description	Amount
Miscellaneous Income	3,918
Investment income in Lexington Financial Services, L.L.C.	1,106
Total line 28	5,024

See Accountants' Compilation Report

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,879,770	1	
2	Restatements (describe):		2	
3	**Prior period adjustment**	(70,886)	3	
4	**Prior year post closing entries**	(245,658)	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,563,226	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	2,120,854	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(3,255,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,134,146)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,429,080	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 12,643,026	1
2	Discounts and Allowances for all Levels	(609,648)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,033,378	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,794,316	6
7	Oxygen	1,260	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,795,576	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,381	12
13	Barber and Beauty Care	41,974	13
14	Non-Patient Meals	145	14
15	Telephone, Television and Radio	40	15
16	Rental of Facility Space		16
17	Sale of Drugs	200,225	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,990	19
20	Radiology and X-Ray	16,465	20
21	Other Medical Services	80,016	21
22	Laundry	3,489	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 356,725	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,045	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,045	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**See attached Schedule E**	5,024	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 5,024	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,193,748	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,618,059	31
32	Health Care	5,383,442	32
33	General Administration	2,384,597	33
	B. Capital Expense		
34	Ownership	1,963,202	34
	C. Ancillary Expense		
35	Special Cost Centers	575,769	35
36	Provider Participation Fee	147,825	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,072,894	40
41	**Income before Income Taxes (line 30 minus line 40)****	2,120,854	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 2,120,854	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity files a cash basis tax return.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,530	2,668	$ 111,382	$ 41.75	1
2	Assistant Director of Nursing	4,240	4,382	118,704	27.09	2
3	Registered Nurses	27,742	28,985	737,124	25.43	3
4	Licensed Practical Nurses	45,054	46,852	1,025,108	21.88	4
5	Nurse Aides & Orderlies	133,040	138,227	1,500,775	10.86	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	11,050	11,712	130,815	11.17	8
9	Activity Director	1,664	1,705	29,937	17.56	9
10	Activity Assistants	22,236	23,014	213,898	9.29	10
11	Social Service Workers	3,707	3,723	67,672	18.18	11
12	Dietician					12
13	Food Service Supervisor	1,782	2,059	31,423	15.26	13
14	Head Cook	1,980	2,059	24,171	11.74	14
15	Cook Helpers/Assistants	20,860	21,595	174,766	8.09	15
16	Dishwashers	15,059	15,465	96,208	6.22	16
17	Maintenance Workers	6,771	7,221	108,928	15.08	17
18	Housekeepers	41,907	44,147	298,514	6.76	18
19	Laundry	8,630	8,998	56,059	6.23	19
20	Administrator	2,083	2,100	94,025	44.77	20
21	Assistant Administrator					21
22	Other Administrative	891	891	118,800	133.33	22
23	Office Manager					23
24	Clerical	26,524	28,301	535,132	18.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	377,750	394,104	$ 5,473,441 *	$ 13.89	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	292	$ 16,818	L1,C3	35
36	Medical Director	Monthly	24,750	L9, C3	36
37	Medical Records Consultant	4	1,000	L10, C3	37
38	Nurse Consultant	19	1,140	L10, C4	38
39	Pharmacist Consultant	12	1,200	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	128	5,993	L11, C3	44
45	Social Service Consultant	52	2,329	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	507	$ 53,230		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	659	$ 13,175	L10, C3	50
51	Licensed Practical Nurses	17	297	L10, C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	676	$ 13,472		53

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Lanter	Administrator	0%	$ 94,025
John Samatas	Admin/Plant Ops	30%	21,376
James Samatas	Administrative	30%	48,096
Cynthia Thiem	Administrative	30%	26,721
George Samatas	Administrative	0%	6,413
Jason Samatas	Administrative	0%	16,194
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 212,825

B. Administrative - Other

Description	Amount
	$
Management fees (eliminated in column 7)	541,191
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 541,191

C. Professional Services

Vendor/Payee	Type	Amount
American Express Tax & Bus.Svs.	Accounting	$ 5,534
Altschuler, Melvoin & Glasser LLP	Accounting	22,142
ING	401(k)	435
Global Care	Consulting	8,019
Nancy Skuble	Psychological Consulting	2,000
James Samatas	Legal	73
Personnel Planners	U/C Consulting	1,567
Sachnoff & Weaver	Legal	40,315
Systematic Management	Billing Consulting	(126)
See attached Schedule F		26,657
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 106,616

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 100,488
Unemployment Compensation Insurance	57,350
FICA Taxes	403,076
Employee Health Insurance	129,269
Employee Meals	14,157
Illinois Municipal Retirement Fund (IMRF)*	
401(k) contribution	8,914
Other employee benefits	13,095
TOTAL (agree to Schedule V, line 22, col.8)	$ 726,349

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	33,432
Health Care Worker Background Check	
(Indicate # of checks performed 90)	1,083
Miscellaneous licenses, permits & inspec.	1,488
Miscellanoeus dues and subscriptions	1,064
Allocated from management company	986
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,253

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,246
Allocated from management company	3,896
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,142

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Lexington Health Care Center of Orland Park, Inc.
Provider # 0041855 **Schedule F**
1/1/02 - 12/31/02

XIX. Support Schedules

C. Professional Services

Vendor/Payee	Type	Amount
Action Computer Service	Computer Consulting	324
Information Controls, Inc.	Computer Consulting	1,084
Advanced Answers on Demand	Computer Consulting	3,247
Gigatrend	Computer Consulting	195
Internet Presence Consulting	Computer Consulting	711
Katten, Muchin, Zavis and Rosenman	Legal	868
Harris Kessler & Goldstein	Legal	2,589
Carol Jescke	Staffing Consultant	739
Glantz - Richman	Rehabilitation Consultant	350
Freidman, Anselmo & Lindberg	Collections	16,550
		26,657
Total, Agrees to Schedule V, Line 19, Column 3		106,616
Allocated from management co.		
Altschuler, Melvoin & Glasser, LLP/ American Express Tax & Business Services	Accounting	978
Brekke Consulting, Inc.	Exec. Counsel Consulting	223
Gilson, Labus and Silverman	Accounting	60
James Samatas	Legal	26
Katten, Muchin, Zavis and Rosenman	Legal	297
Sachnoff and Weaver	Legal	162
ING / Pension Administrators / Aetna Life Insurance & Annuity Co.	401 (k) Administration	724
Various	Consulting	148
Various	Computer Consulting	10,254
Allocated from building partnership		
James Samatas	Legal	83
Nonallowable legal fees		
Freedman, Anselmo, & Lindberg	Legal-collection fees	(16,550)
Sachnoff & Weaver	Out of period fees	(1,572)
Out of period professional fees		
Global Care	Out of period fees	(8,019)
Total, Agrees to Schedule V, Line 19, Column 8		93,430

See Accountants' Compilation Report.

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Painting & decorating	2000	$ 2,198	3	$	$ 366	$ 733	$ 733	$ 366	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,198		$	$ 366	$ 733	$ 733	$ 366	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lexington of Orland Park # 0041855 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **72,404** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **147,825**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **14,157** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **145**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Lexington of Orland Par** **03:22 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-1,252,299	equal to	-1,252,299	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	571,125	equal to	571,125	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	468,540	equal to	468,540	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	345,347	equal to	345,347	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	13,679	equal to	13,679	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	1,078,686	equal to	1,078,686	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	211,482	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,618,059	equal to	1,618,059	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	5,383,442	equal to	5,383,442	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,384,597	equal to	2,384,597	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	1,963,202	equal to	1,963,202	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	575,769	equal to	575,769	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	147,825	equal to	147,825	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	3,493,093	equal to	3,623,908	-130,815	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	243,835	equal to	243,835	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	67,672	equal to	67,672	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	326,568	equal to	326,568	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	108,928	equal to	108,928	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	298,514	equal to	298,514	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	56,059	equal to	56,059	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	212,825	equal to	212,825	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	535,132	equal to	535,132	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	5,473,441	equal to	5,473,441	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	16,818	< or = to	16,818	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	24,750	< or = to	24,750	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	16,812	< or = to	24,475	-7,663	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	5,993	< or = to	5,993	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,329	< or = to	2,329	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	212,825	equal to	212,825	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	541,191	equal to	541,191	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	106,616	equal to	106,616	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	726,349	equal to	726,349	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	38,253	equal to	38,253	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	6,142	equal to	6,142	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	147,825	equal to	147,825	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	14,157	< or = to	87,174	-73,017	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	14,157	equal to	14,157	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	8,982	equal to	15,282	-6,300	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-85,343	equal to	-85,343	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	8,984,584	equal to	8,984,584	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	480,000	equal to	480,000	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	798,160	equal to	798,160	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	9,088,696	equal to	9,088,696	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,055,326	equal to	1,055,326	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,988,656	equal to	1,988,656	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	2,429,080	equal to	2,429,080	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	2,120,854	equal to	2,120,854	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	366	equal to	366	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	4,962,909	equal to	4,962,909	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	326,568	40,024	16,818	383,410	0	383,410	0	383,410
2. Food P	0	355,875	0	355,875	0	355,875	-14,302	341,573
3. Housek	298,514	49,624	0	348,138	0	348,138	929	349,067
4. Laundry	56,059	29,619	0	85,678	0	85,678	-3,489	82,189
5. Heat ar	0	0	207,165	207,165	0	207,165	4,962	212,127
6. Mainter	108,928	0	128,865	237,793	0	237,793	2,099	239,892
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	790,069	475,142	352,848	1,618,059	0	1,618,059	-9,801	1,608,258
9. Medical	0	0	24,750	24,750	0	24,750	0	24,750
10. Nursin	3,623,908	293,930	24,475	3,942,313	0	3,942,313	0	3,942,313
10a. Ther	0	0	1,078,686	1,078,686	0	1,078,686	0	1,078,686
11. Activit	243,835	17,864	5,993	267,692	0	267,692	0	267,692
12. Social	67,672	0	2,329	70,001	0	70,001	0	70,001
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total I	3,935,415	311,794	1,136,233	5,383,442	0	5,383,442	0	5,383,442
17. Admin	212,825	0	541,191	754,016	0	754,016	-541,191	212,825
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	106,616	106,616	0	106,616	-13,186	93,430
20. Fees,	0	0	35,785	35,785	0	35,785	2,468	38,253
21. Clerica	535,132	38,555	34,513	608,200	0	608,200	28,315	636,515
22. Emplo	0	0	639,175	639,175	0	639,175	87,174	726,349
23. Inserv	0	0	913	913	0	913	0	913
24. Travel	0	0	2,246	2,246	0	2,246	3,896	6,142
25. Other	0	0	0	0	0	0	12,777	12,777
26. Insura	0	0	237,646	237,646	0	237,646	4,245	241,891
27. Other	0	0	0	0	0	0	0	0
28. Total (	747,957	38,555	1,598,085	2,384,597	0	2,384,597	-415,502	1,969,095
29. Total (	5,473,441	825,491	3,087,166	9,386,098	0	9,386,098	-425,303	8,960,795
30. Depre	0	0	38,340	38,340	0	38,340	307,007	345,347
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	11,299	11,299	0	11,299	559,826	571,125
33. Real E	0	0	0	0	0	0	468,540	468,540
34. Rent -	0	0	1,905,749	1,905,749	0	1,905,749	########	0
35. Rent -	0	0	7,814	7,814	0	7,814	5,865	13,679
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	1,963,202	1,963,202	0	1,963,202	-564,511	1,398,691
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	211,482	67,093	278,575	0	278,575	0	278,575
40. Barbe	0	0	34,061	34,061	0	34,061	0	34,061
41. Coffee	0	0	648	648	0	648	0	648
42. Provid	0	0	147,825	147,825	0	147,825	0	147,825
43. Other	0	0	262,485	262,485	0	262,485	-262,485	0
44. Total S	0	211,482	512,112	723,594	0	723,594	-262,485	461,109
45. Grand	5,473,441	1,036,973	5,562,480	########	0	########	########	########

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	933,480	936,847
2. Cash - F	0	0
3. Account	3,556,202	3,556,202
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	87,351	87,351
7. Other Pr	0	0
8. Account	43,621	51,428
9. Other (s	0	0
10. Total c	4,620,654	4,631,828
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	79,301	79,301
13. Land	0	798,160
14. Buildin	0	8,569,286
15. Leaseh	156,927	519,410
16. Equipn	229,878	1,055,326
17. Accum	-123,851	########
18. Deferre	0	366
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other l	0	0
23. other (s	0	139,412
24. Total L	342,255	9,172,605
25. Total A	4,962,909	########
CURRENT LIABILITIES		
26. Accour	557,420	557,420
27. Officer'	0	0
28. Accour	588,197	588,197
29. Short-T	0	14,584
30. Accrue	214,556	214,556
31. Accrue	9,393	9,393
32. Accrue	0	480,000
33. Accrue	0	67,574
34. Deferre	0	0
35. Federa	0	0
36. Other (	564,263	109,304
37. Other (	0	0
38. Total C	1,933,829	2,041,028
LONG TERM LIABILITES		
39.Long-T	600,000	600,000
40.Mortgag	0	8,370,000
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	868,466
44.Other L	0	0
45.Total Lo	600,000	9,838,466
46.Total Li	2,533,829	########
47.Total Eq	2,429,080	1,924,939
48.Total Li	4,962,909	########

		Balance per Medicaid Trial Balance
1.	Gross F	########
2.	Discour	-609,648
	Subtota	########
4.	Day Ca	0
5.	Other C	0
6.	Therap	1,794,316
7.	Oxygen	1,260
	Subtota	1,795,576
9.	Paymer	0
10.	Other	0
11.	Nurse	0
12.	Gift an	1,381
13.	Barbe	41,974
14.	Non-P	145
15.	Teleph	40
16.	Rental	0
17.	Sale o	200,225
18.	Sale o	0
19.	Labora	12,990
20.	Radiol	16,465
21.	Other	80,016
22.	Laund	3,489
	Subtot	356,725
24.	Contril	0
25.	Interes	3,045
	Subtot	3,045
27.	Other	5,024
28.	Other	0
	Subtot	5,024
30.	Total F	########
31.	Gener	1,618,059
32.	Health	5,383,442
33.	Gener	2,384,597
34.	Owner	1,963,202
35.	Specia	575,769
35.	Provid	147,825
37.	Other	0
40.	Total E	########
41.	Incom	2,120,854
42.	Incom	0
43.	Net In	2,120,854

Page

Line 16 for mortgage insurance.